DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

APPLICATION FOR FREE STANDING EMERGENCY CENTER LICENSE

FACILITY NAME _____
Print

FACILITY ADDRESS _____
ADDRESS 1

_____
ADDRESS 2

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR/CEO _____
Print

MEDICAL DIRECTOR _____
Print

M.D. License #:_____ Exp. Date:_____

DIRECTOR OF NURSING _____
Print

R.N. License #:_____ Exp. Date:_____

FACILITY CONTACT _____
Print Name and Title

PHONE NUMBERS _____ _____ _____
FACILITY PHONE NUMBER CONTACT PHONE NUMBER CONTACT FAX

NUMBER OF EMERGENCY BAYS ☐

ACCREDITED? ☐ YES BY WHOM: _____
Include effective expiration dates per agency _____

_____

☐ NO

ALL PHYSICIANS ARE CERTIFIED IN ACLS OR EMERGENCY MEDICINE ☐ YES ☐ NO

AT LEAST ONE NURSE ON EACH SHIFT IS CERTIFIED IN ACLS ☐ YES ☐ NO

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES AND ADDRESSES OF EACH OFFICER, DIRECTOR, AND OWNER HAVING TEN (10) PERCENT OR MORE INTEREST IN THE FACILITY.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. ACCREDITING AGENCY(IES) CERTIFICATE(S) AND REPORT(S)
4. FIRE SAFETY REPORT
5. OTHER:_____

_____

****PLEASE ATTACH A TABLE SHOWING TWENTY-FOUR (24) HOUR STAFFING****

NAME OF PERSON COMPLETING THIS FORM:_____
PRINT

SIGNATURE:_____ TITLE:_____

DATE:_____

CHECKS SHOULD BE MADE PAYABLE TO: **DELAWARE DIVISION OF PUBLIC HEALTH**

INITIAL APPLICATION FEE:
$250.00

ANNUAL LICENSURE FEE:
$150.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
2055 LIMESTONE ROAD
SUITE 200
WILMINGTON DE 19808

02/05